MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02413 02370

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN — 3 years — 14-1
d. STREET ADDRESS: 208 Mt. Vernon X Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: NMN — Last: Carson

4. DATE OF DEATH: Month: February — Day: 3 — Year: 19 66

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 8-13-1900 — 9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oliver Scandrol (D)
14. MOTHER'S MAIDEN NAME: Elizabeth McNickel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital XXXXXXX Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-7 hours
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis — unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-1, 1966, to 2-3, 1966, that (I) (we) last saw the deceased alive on 2-3 19 66, and that death occurred at 4½ M, from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-4-66
22c. PHYSICIAN'S NAME (Type): DR. ROBERT W. FARR
22d. ADDRESS: CHESTERTOWN, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/7/66
23c. NAME OF CEMETERY OR CREMATORY: Jefferson Memorial
23d. LOCATION (City, town or county) (State): Pittsburgh, Pa.

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: FEB 7 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02414

CERTIFICATE OF DEATH

02371

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD — b. COUNTY: Kent.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 14-1
d. STREET ADDRESS: P.O. Box 82
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Rebecca Marie — Middle — Last Coleman

4. DATE OF DEATH: Month Feb — Day 1 — Year 1966

5. SEX: Fe

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/1/66

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 2 — Min. 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Coleman

14. MOTHER'S MAIDEN NAME: Agnes Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ANOXIA — INTERVAL BETWEEN ONSET AND DEATH: 2 Min 760

7625

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): FAILURE TO INITIATE RESPIRATION AT BIRTH — 11

DUE TO (c): PREMATURITY

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-1-, 1966, to 2-1, 1966, that (I) (we) last saw the deceased alive on 2-1-66 19, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: O.S. Gulbrandsen — M.O. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-1-66

22c. PHYSICIAN'S NAME (Type): DR. O. S. Gulbrandsen

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/2/66

23c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

23d. LOCATION (City, town or county) (State): X Chestertown, Md.

24. FUNERAL DIRECTOR: J. Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 4 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

B-169853

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02415 — 02372

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington 14-1
d. STREET ADDRESS: R#1 Box 325A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BRIAN — Middle: ~~ALAN~~ — Last: Collins

4. DATE OF DEATH: Month: Feb. — Day: 14 — Year: 1966

5. SEX: Male — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 2-13-66 — 9. AGE (In years last birthday) yrs.: — IF UNDER 1 YEAR Months: — Days: 1 — IF UNDER 24 HRS. Hours: 13 — Min.: 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Albert Collins
14. MOTHER'S MAIDEN NAME: Joan Yvonne Pearson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Fetal atelectasis	36 hrs
DUE TO (b)	Prematurity	"
DUE TO (c)	Partial premature separation of placenta	1 mo?

7615

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-13, 1966 to 2-14, 1966, that (I) (we) last saw the deceased alive on 2-14 1966, and that death occurred at 4:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: O.S. Gulbrandsen
M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-14-66
22c. PHYSICIAN'S NAME (Type): O.S. GULBRANDSEN, M.D.
22d. ADDRESS: CHESTERTOWN, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB. 16, 1966
23c. NAME OF CEMETERY OR CREMATORY: MILLINGTON CEMETERY
23d. LOCATION (City, town or county) (State): MILLINGTON MARYLAND

24. FUNERAL DIRECTOR: Edward Fellows — ADDRESS: Millington, Md.
25a. REC'D BY REGISTRAR DATE: FEB 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

6-169861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02416

CERTIFICATE OF DEATH

02373

1. PLACE OF DEATH
a. COUNTY: Kent
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside carporate limits, write RURAL and give neorest town): Rock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie Middle: Elizabeth Last: Dameron

4. DATE OF DEATH: Month: February Day: 16 Year: 19 66

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-9-20

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oyster shucker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: -Elias Davenport (D)

14. MOTHER'S MAIDEN NAME: Mary Louise Cook (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-20-0680

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201
INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Intestinal Obstruction & Perforation

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-16, 1966, to 2-16, 1966, that (I) (we) last saw the deceased alive on 2-16 1966 and that death occurred at 8:15 M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2.16.66

22c. PHYSICIAN'S NAME (Type): Dr. Arthur T. Keefe

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/18/1966

23c. NAME OF CEMETERY OR CREMATORY: SHARPTOWN CEMETERY

23d. LOCATION (City or Town) (County) (State): ROCK HALL, MD.

24. FUNERAL DIRECTOR: Kennett Cade ADDRESS: Chestertown, Md

25a. RECD BY REGISTRAR DATE: FEB 21 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02417

CERTIFICATE OF DEATH

02374

1. PLACE OF DEATH
a. COUNTY: Kent County, Maryland — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): R.F.D. Worton, Md.
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): At Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. Worton, Maryland 14-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Annie; Middle; Last Downing

4. DATE OF DEATH: Month 2; Day 7; Year 1966

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/27/1900

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (County & State, or foreign country): Kent County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDGAR BARROLL

14. MOTHER'S MAIDEN NAME: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 219-30-8565

17. INFORMANT: Russell Phillips Address: R.F.D. Worton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardio-Vascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Rheumatic heart — About 5 years

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-10-, 1965, to 1-23-, 1966, that (I) (we) last saw the deceased alive on 1-23- 1966, and that death occurred at 1 P M, from the causes and on the date stated above.

22a. SIGNATURE: Rudolf Eglitis M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-9-66.

22c. PHYSICIAN'S NAME (Type): Rudolfs Eglitis M.D.

22d. ADDRESS: Rock Hall, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/12/1966

23c. NAME OF CEMETERY OR CREMATORY: Saint George Cem.

23d. LOCATION (City, town or county) (State): R.F.D. Worton, Md.

24. FUNERAL DIRECTOR: Kenneth Walley ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02413

CERTIFICATE OF DEATH

02375

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Kent — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
   c. LENGTH OF STAY IN 1b: 71/2 hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Kent
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
   d. STREET ADDRESS: 131 Queen Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: First Baby Boy of Triplets; Middle: ; Last: HESSION ~~Walbert~~

4. DATE OF DEATH: Month: 2; Day: 12; Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/12/1966

9. AGE (In years last birthday): yrs.
   IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: 7; Min.: 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Kent Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Patrick Calvert Hession

14. MOTHER'S MAIDEN NAME: Mary Lee Walbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Premcturity (1#-8½oz)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

7735

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/12, 19 66, to 2/12, 19 66 that (I) (we) last saw the deceased alive on 2/12 19 66, and that death occurred at 7:50A.M, from the causes and on the date stated above.

22a. SIGNATURE: O Gulbrandsen — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-13-66

22c. PHYSICIAN'S NAME (Type): Dr. Oskar Gulbrandsen

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/13/66

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.

23d. LOCATION (City, town or county) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR: Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

116-133548

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02419 02376

1. PLACE OF DEATH
e. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: Hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 131 Queen Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: 2nd Baby Boy of Triplets — Middle: — Last: Hession
4. DATE OF DEATH: Month: 2 — Day: 12 — Year: 19 66
5. SEX: MALE / Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/12/1966
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 15 — Min.: 40
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Kent Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Patrick Calvert Hession
14. MOTHER'S MAIDEN NAME: Mary Lee Walbert
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Records — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
DUE TO (b): Prematurity (1# (3/4g))
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-12, 1966, to 2-12, 1966 that (I) (we) last saw the deceased alive on 2-12 1966, and that death occurred at 4:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Oskar Gulbrandsen — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-13-66
22c. PHYSICIAN'S NAME (Type): Dr. Oskar Gulbrandsen
22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/13/66
23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem
23d. LOCATION (City, town or county) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR: J. Willis Wells
ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: FEB 15 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

6-133578

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02420

CERTIFICATE OF DEATH

02377

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
14 - 1
d. STREET ADDRESS: 131 Queen Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: 3rd of triplets - Baby Girl; Middle: ; Last: Hession

4. DATE OF DEATH: Month: 2; Day: 12; Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/12/1966

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: 14; Min.: 5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Kent Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Patrick Calvert Hession

14. MOTHER'S MAIDEN NAME: Mary Lee Walbert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records — Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure
7735
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Prematurity (1# 7½ oz)
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-12, 1966, to 2-12, 1966, that (I) (we) last saw the deceased alive on 2-12 1966, and that death occurred at 3:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Oskar Gulbrandsen — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-13-66

22c. PHYSICIAN'S NAME (Type): Dr. Oskar Gulbrandsen

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/13/66

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cem.

23d. LOCATION (City, town or county) (State): Rock Hall, Md.

24. FUNERAL DIRECTOR: Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

6-133513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14 — 02421 — (M) — 02378

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7-62

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 91 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 121 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

14-1

3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Marietta	(None)	Loud

4. DATE OF DEATH	Month	Day	Year
	2	18	19 66

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		10/10/84	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School teacher	Teaching	Kent Co., Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Cordroy Loud	Annie Groves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	215-36-1603	Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO (b): Ca of uterus — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/19, 1965, to 2/18, 19 66 that (I) (we) last saw the deceased alive on 2/18 19 66, and that death occurred at 9:15 pm from the causes and on the date stated above.

22a. SIGNATURE: A. C. Dick M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2-18-66

22c. PHYSICIAN'S NAME (Type): A. C. Dick, M.D. — 22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2/21/66	Chester Cem.	Chestertown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md. — 25a. REC'D BY REGISTRAR DATE: FEB 23 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02422 — 02379

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7-62

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 18 hours

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena rural
d. STREET ADDRESS: 14-1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Ke nt & Queen Annes

67

3. NAME OF DECEASED (Type or print): First: Harold — Middle: — Last: Lucas

4. DATE OF DEATH: Month: Feb — Day: 5 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: colored

7. MARRIED [ ] **NEVER MARRIED** [XX] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: April 11,(1918?)

9. AGE (In years last birthday): 47? yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, aven if retired): Farm laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Virgin i a

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jeff Lucas

14. MOTHER'S MAIDEN NAME: Beat rice Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-12-7356

17. INFORMANT Address: Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary infarction and/or bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Cardiac decom pensation — several weeks

DUE TO (c): Probable arteriosclerotic cardiovascular disease with tremendous cardiac dil ation — unknown

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/4, 1966, to 2/5, 1966, that (I) (we) last saw the deceased alive on 2/5, 1966, and that death occurred at 12.30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert W Farr M.D.

ATTENDING PHYS. [XX] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 2/6/66

22c. PHYSICIAN'S NAME (Type): Robert W. Farr

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 12, 1966

23c. NAME OF CEMETERY OR CREMATORY: Bethel A.M.E.Cemetery

23d. LOCATION (City, town or county) (State): Golts, Kent Co; Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington Md.

25a. REC'D BY REGISTRAR DATE: FEB 10 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02423 02380

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 231 Kent Circle

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 14-1
d. STREET ADDRESS: 231 Kent Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frances Howard Middle Mc Ginnes Last
4. DATE OF DEATH: Month Feb. Day 4 Year 1966
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 4, 1896
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Chestertown, Kent, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Howard
14. MOTHER'S MAIDEN NAME: Mary Jane Mc Kevitt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 184-22-0609
17. INFORMANT: Edgar A. Mc Ginnes, Address: Chestertown, Md. 231 Kent Circle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive arterio sclerotic cardio-vascular renal disease — 8 to 10 yrs
DUE TO (c):
4424

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1965 to Feb. 4, 1966, that (I) (we) last saw the deceased alive on Feb. 4 1966, and that death occurred at 2 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/5/66
22c. PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.
22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 7, 1966
23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
23d. LOCATION (City, town or county) (State): Chestertown, Maryland
24. FUNERAL DIRECTOR: Marvin V. Williams, ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR DATE: FEB 9 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02424

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02381

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Kent
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
   c. LENGTH OF STAY IN 1b: Transient
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne Hosp. Emergency Room

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Queen Anne's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suddlersville, Md -
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carolyn; Middle: Alice; Last: McKinney

4. DATE OF DEATH: Month: February; Day: 17; Year: 1966

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 22, 1965

9. AGE (In years last birthday): yrs. 5 — IF UNDER 1 YEAR: Months, Days 22 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Clifton McKinney

14. MOTHER'S MAIDEN NAME: Linda Lee Emory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Linda Lee McKinney — Address: Suddlersville, Md -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probable septicemia with tribulent otitis media — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days

3912

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robt Farr — M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 2-17-66

EXAMINER'S NAME (Type): ROBERT W. FARR

Address (Street, city, town, or county): Chestertown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 18

23c. NAME OF CEMETERY OR CREMATORY: BUSIC

23d. LOCATION (City, town or county) (State): NEAR BARCLAY MD

24. FUNERAL DIRECTOR: Edgar L. Lane — ADDRESS: Church Hill, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME
3500 4-64

5-133590

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

02425

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02382

1. PLACE OF DEATH
a. COUNTY: KENT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): XX

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL 14-1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES Middle WILLIAM Last MILLER

4. DATE OF DEATH: Month FEB. Day 18 Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: AUG. 8 1908

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or Foreign country): KENT Co. MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES A. MILLER

14. MOTHER'S MAIDEN NAME: LENA ATKINSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-30-6660

17. INFORMANT: MRS. CHAS. MILLER Address: ROCK HALL, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage - C.V.A.
331X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 15 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-18-, 1965, to 1-17-, 1966, that (I) (we) last saw the deceased alive on 1-17-1966, and that death occurred at 4.45 M, from the causes and on the date stated above.

22a. SIGNATURE: Rudolf Eglitis M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 2-19-66.

22c. PHYSICIAN'S NAME (Type): RUDOLFS EGLITIS

22d. ADDRESS: ROCK HALL, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 21

23c. NAME OF CEMETERY OR CREMATORY: WESLEY CHAPEL

23d. LOCATION (City, town or county) (State): ROCK HALL MD.

24. FUNERAL DIRECTOR: Edgar L. Lane ADDRESS: Church Hill, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02426 — 02383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 80 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Robert — Middle Lewis — Last Miller (MILLER)

4. DATE OF DEATH: Month February — Day 17 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-19-1901

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired from Sun Oil Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Hartford Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Miller (D)

14. MOTHER'S MAIDEN NAME: Elizabeth Walker (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 163 09 6137

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma,
DUE TO (b): primary site unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-29, 1965, to 2-17, 1966, that (I) (we) last saw the deceased alive on 2-17, 1966, and that death occurred at 6 P.M, from the causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2.18.66

22c. PHYSICIAN'S NAME (Type): Dr. Arthur T. Keefe

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/22/66

23c. NAME OF CEMETERY OR CREMATORY: Lawn Croft Cem

23d. LOCATION (City, town or county) (State): Boothwyn (Del. Co.) Pa.

24. FUNERAL DIRECTOR: J. Willis Wells

ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 21 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

Kent Maryland Kent

Chestertown 90 days Rock Hall

Kent & Queen Anne's Hospital Reach Road

Robert Lewis February 17 65

X

Male White 10-19-1901 64

Retired from Sun Oil Co. Retired Co., Maryland U.S.A.

Robert Miller (D) Elizabeth Walker (D)

No Hospital Records

2-17 66 11-29 65 2-17 66

Dr. Arthur T. Keefe Chestertown, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02427 — 02384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1. **PLACE OF DEATH**
   a. COUNTY: Kent — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
   c. LENGTH OF STAY IN 1b: 5 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne's Hospital

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Queen Anne's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Church Hill 17-2
   d. STREET ADDRESS: Box 41B
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Martha — Middle: Lucille — Last: Reese

4. **DATE OF DEATH**: Month: February — Day: 8 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 6, 1921

9. AGE (In years last birthday): 44 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vita Food Products

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Queen Anne's Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas R. Fenwick

14. MOTHER'S MAIDEN NAME: Abbie Tilghman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 219-07-6711

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia
490 ?
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Intestinal Obstruction due to Carcinoma of Colon

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-3, 1966, to 2-8, 1966, that (I) (we) last saw the deceased alive on 2-8 1966, and that death occurred at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-8-66

22c. PHYSICIAN'S NAME (Type): Dr. Arthur T. Keefe

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): B&B A

23b. DATE THEREOF: 2/12/1966

23c. NAME OF CEMETERY OR CREMATORY: Richneck Hall Cem.

23d. LOCATION (City, town or county) (State): (near) Church Hill, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wolby — ADDRESS: Chestertown, Md

25a. REC'D BY REGISTRAR DATE: FEB 11 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

Kent | Maryland | Queen Anne's

Chestertown | 3 days | Church Hill

Kent & Queen Anne's Hospital | Box 418

Martha | Lucille | Reese | February | 8 | 66

Female | Negro | May 6, 1921 | 44

Vita Food Products | Queen Anne's Co., Maryland | U.S.A.

Thomas R. Fenwick | Abbie Tilghman

No | Hospital Records

2-8 | 66 | 2-3 | 66 | 2-8 | 66

Dr. Arthur T. Keefe | Chestertown, Maryland

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02423

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02385

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne Hospital (12 hours)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown (rural — (Lifetime)
d. STREET ADDRESS: RFD 17-2
e. IS RESIDENCE ON A FARM? YES XX NO ☐

3. NAME OF DECEASED (Type or print): First Blair — Middle Lee (Bradford) — Last SMITH

4. DATE OF DEATH: Month Feb. — Day 11, — Year 1966

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/17/1915

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm Owner

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John C. Smith, Sr.

14. MOTHER'S MAIDEN NAME: Bertha Barton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217 36 0184

17. INFORMANT: Miss Thelma Smith — Address: Riverdale, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Severe injury to head and brain with no evidence	
DUE TO (b)	by xray of skull fracture. Possible high transection of cord since he had only	12 hrs
DUE TO (c)	diaphragmatic breathing	12 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple fractures of right ribs, small pneumothorax rt. lung, cerebral shock

19. WAS AUTOPSY PERFORMED? YES ☐ NO XX

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter Nature of Injury in Part I or Part II of Item 18.): Struck by ice cream truck in crossing accident

20c. TIME OF INJURY Hour c. 2 p.m. Month, Day, Year 2/10 66 19

20d. INJURY OCCURRED While at work ☐ Not While at work XX

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway

20f. (City or town) nr Chestertown (County) (QA) (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection XX, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr — M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX

EXAMINER'S NAME (Type): Robert W. Farr

Address (Street, city, town, or county): Chestertown, Kent Co., Maryland

22. DATE SIGNED: 2/12/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/13/66

23c. NAME OF CEMETERY OR CREMATORY: Church Hill Cem.

23d. LOCATION (City, town or county): Church Hill, Md. (State)

24. FUNERAL DIRECTOR: J. Willis Wells — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
350D 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02429

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02386

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address): Kent & Queen Annes General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Annes
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Church Hill 17-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Grover — Middle: — Last: Stubbs

4. DATE OF DEATH: Month: Feb — Day: 5 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 1882

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm labore r

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: No Record

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Hospital Records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Toxemia and circulatory fail ure — INTERVAL BETWEEN ONSET AND DEATH: 10-14 days

9160

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): 3rd degree burns of right side of thorax and of right arm — 25 days

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Advanced generalized arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Clothes caughtfire while he was lighting a gas stove. Re mained confused & in poor condition& gradually developed signs of con- gestive failure & Circulatory collapse

20c. TIME OF INJURY, Month, Day, Year: 5 Hour xxx p.m. 1/11/66 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town) Church Hill (County) Qu.Annes (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr M.D.

EXAMINER'S NAME (Type): Robert W. Farr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county): Chestertown, Md.

22. DATE SIGNED: 2/5/66

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-7-66

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olive

23d. LOCATION (City, town or county) (State): Goldsboro Rural Delaware

24. FUNERAL DIRECTOR — ADDRESS: J. E. Boulais Greensboro, Md.

25a. REC'D BY REGISTRAR DATE: FEB 10 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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FOR STATE HEALTH DEPT. (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02430 02387

1. PLACE OF DEATH
a. COUNTY Kent
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Worton (rural)
c. LENGTH OF STAY IN 1b 10 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE Maryland b. COUNTY Kent
c. CITY OR TOWN (if outside corporate limits, write RURAL and give neerest town) Worton (rural)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

14-1

3. NAME OF DECEASED (Type or print) First Viola Middle Mae Last Taylor
4. DATE OF DEATH Month Feb. Day 25 Year 19 66
5. SEX Female
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5/22/1900
9. AGE (In years last birthday) 65 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH PARKER
14. MOTHER'S MAIDEN NAME ERIE BENSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) no (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 222 18 6946
17. INFORMANT Address Mervin Taylor, Worton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH sev. years
4221
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b) She had been sick for some time, at least a month & had been very short of breath as well as having considerable swelling o f both legs. She belonged to a
DUE TO (c) Sect who do notbelieve in medical care. Discussion

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) with her husband suggests the probabilityof congestive heart failure. She died 6:30 A.M.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Robert W Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED 2/25/66

EXAMINER'S NAME (Type) Robert W. Farr, M. D.
Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 3/1/1966
23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY
23d. LOCATION (City, town or county) (State) R.F.D WORTON Md.

24. FUNERAL DIRECTOR Kenneth Walley ADDRESS Chestertown, md
25a. REC'D BY REGISTRAR DATE MAR 1 1966
25b. REGISTRAR'S SIGNATURE J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02431 02388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all cases, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Kent County, Maryland — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and giva nearest town): Chestertown, Maryland
c. LENGTH DF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent County
c. CITY OR TOWN (If outside limits, write RURAL and giva nearest town): R.F.D.#1 Millington, Maryland
d. STREET ADDRESS: 14-1
e. IS RESIDENCE DN A FARM? YES ☐ ND ☒

3. NAME OF DECEASED (Type or print): First: Emma; Middle: ; Last: Wilson

4. DATE DF DEATH: Month: 2; Day: 14; Year: 19 66

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/3/1891

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL DCCUPATIDN (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Various

11. BIRTHPLACE (County & State, or foreign country): Kent County, Maryland

12. CITIZEN OF WHAT CDUNTRY? U.S.A.

13. FATHER'S NAME: John Wilson

14. MOTHER'S MAIDEN NAME: Janie Frisby

15. WAS DECEASED EVER IN U.S. ARMED FDRCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SDCIAL SECURITY ND.: 218-20-3690

17. INFORMANT: Miss.Olivia Wilson — Address: R.F.D.#1 Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
Conditions, if any, which gava rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of Pancreas — 8 days
DUE TO (c): Hypertension + Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIDNS CDNTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Atrial fibrillation — 19. WAS AUTDPSY PERFORMED? YES ☐ ND ☒

20a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-14, 19 66 to 2-14, 19 66, that (I) (we) last saw the deceased alive on 2-14 19 66 and that death occurred at 7:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Farr — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 3-15-66

22c. PHYSICIAN'S NAME (Type): Robert W. Farr M.D.

22d. ADDRESS: Chestertown, Maryland

23a. BURIAL, CREMATIDN, REMOVAL (Specify): Burial

23b. DATE THEREDF: 2/19/1966

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City, town or county) (State): (NEAR) Millington Md

24. FUNERAL DIRECTOR: Kenneth Walker — ADDRESS: Chestertown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 17 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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